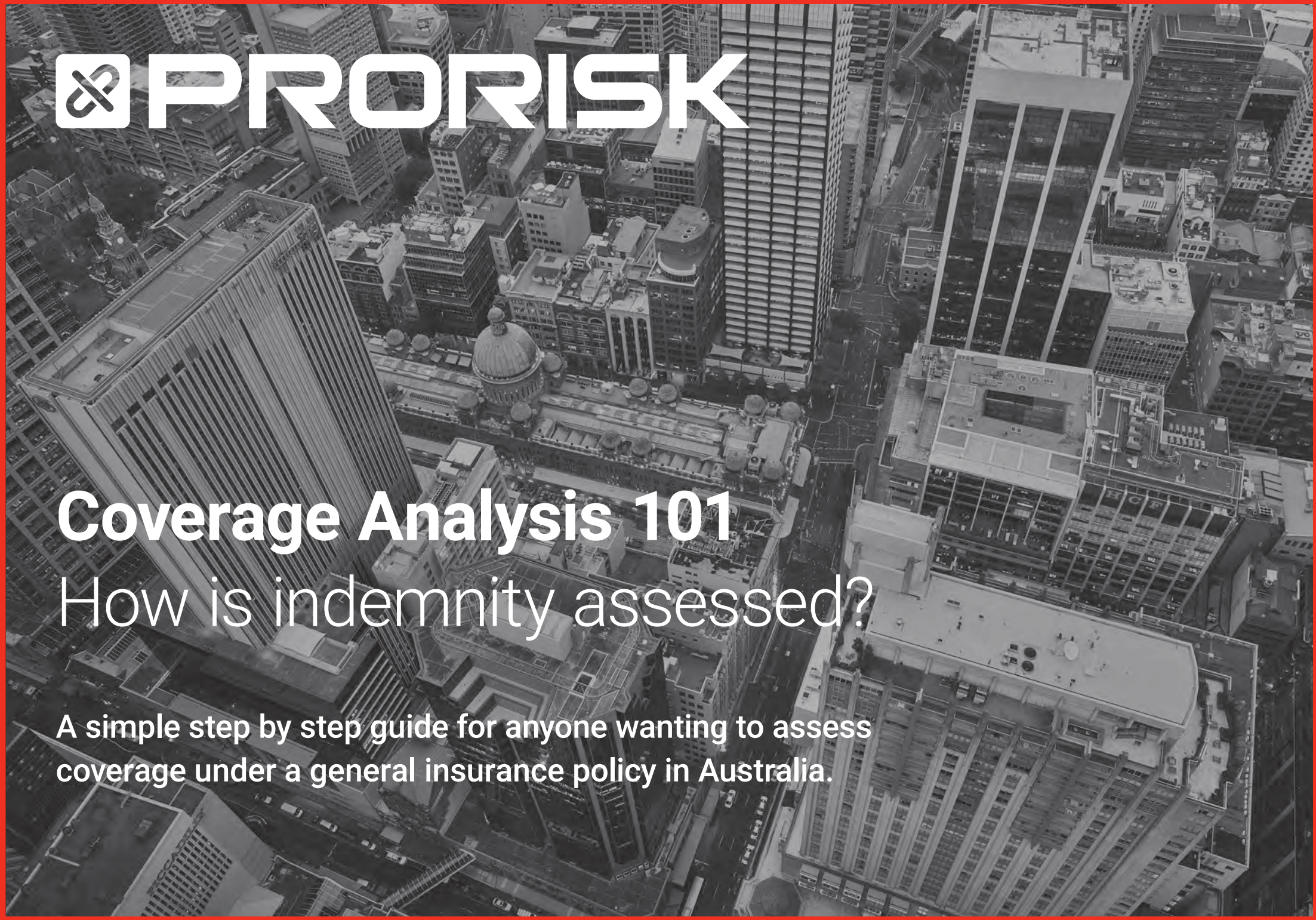

PRORISK
Coverage Analysis 101
How is indemnity assessed?
A simple step by step guide for anyone wanting to assess coverage under a general insurance policy in Australia.

A simple step by step guide for anyone wanting to assess coverage under a general insurance policy in Australia.

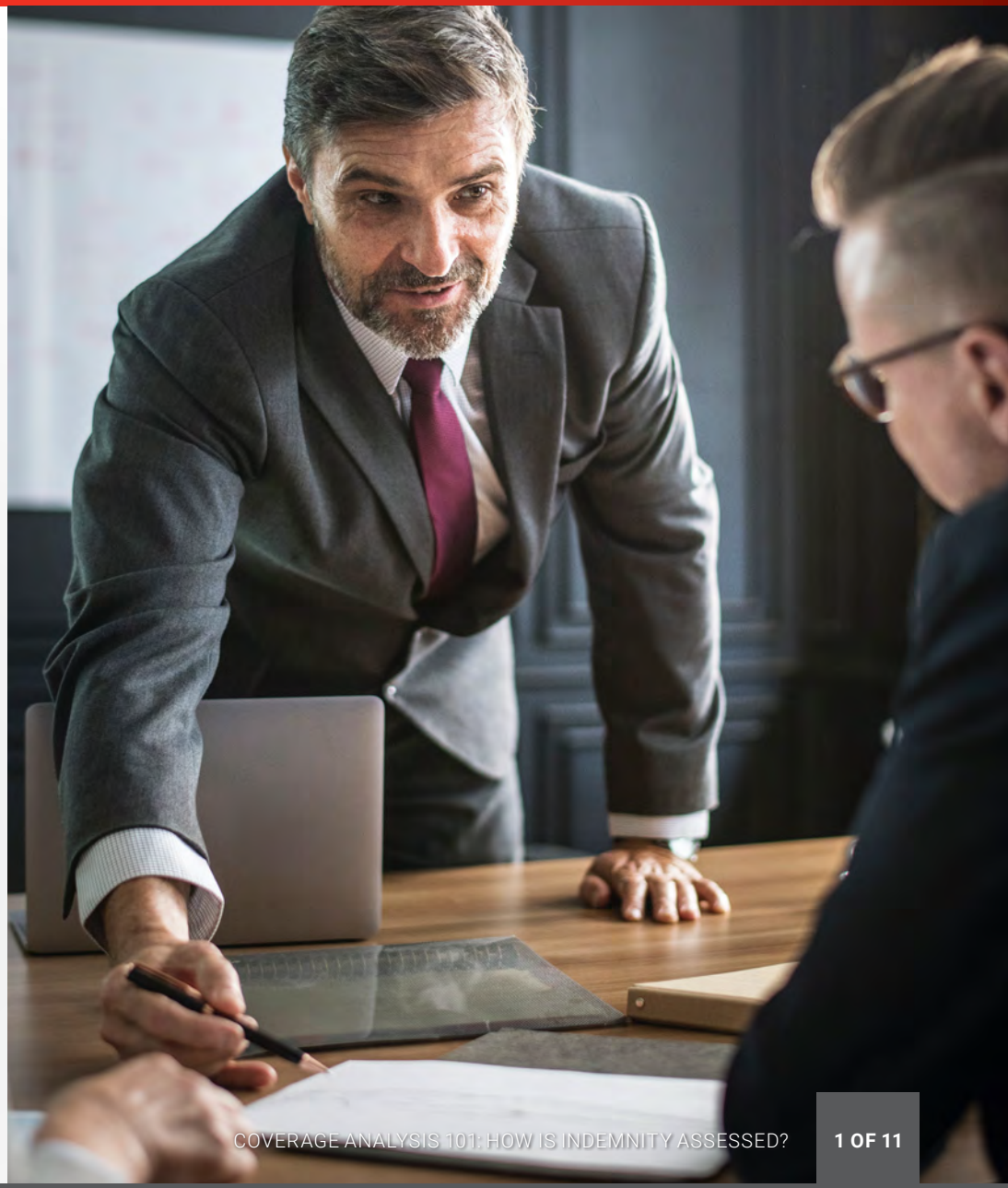
Reviewing the coverage position under a policy of insurance is often viewed as a daunting task. When you pick up an insurance policy and read it, there's lots of fine print and legal concepts that you need to get your head around. That's because it's not a novel, it's a legal document which is designed to be read having regard to a particular factual scenario and the terms, conditions and exclusion of cover.

Where a lot of people go wrong in making an assessment of coverage is to have a quick look over the facts and to expect to find a single sentence in a policy which says "this is covered" or "this is excluded". They expect a quick and simple answer. Understanding that coverage analysis is a process, means that sometimes not all information is presently available and more may be required. In certain circumstances, a coverage decision may not be made immediately by the insurer and additional information may be requested.

Coverage analysis, when completed correctly and thoroughly is a process which will lead the assessor to a conclusion as to whether the policy will respond to a factual scenario and to what extent.

This paper outlines a simple to follow logical process that brokers, claims staff, lawyers, insureds or loss assessors can use to analyse the indemnity position with respect to any given factual scenario.

The purpose of this article is to help demystify the process of how insurers assess coverage. As you will see, there are 10 simple steps that, if followed correctly, will help give you the correct coverage response.



Step 1: Review the facts

The first and most important step in reviewing coverage under a policy of insurance is to know all of the relevant facts. This may seem like a simple task, but often when there are multiple parties involved, getting in contact with everyone to obtain statements and to put everything into an intelligible form can be difficult and time consuming. Sometimes one of the most difficult questions to answer, is what's relevant and what's not.

All relevant documents should be sourced and provided to the insurer to consider as early as possible. If documents are missing, then the insurer will need to request further information, which will delay the process further. Insurance companies are often busy places of work and claims staff are dealing with multiple claims simultaneously, so when a claims officer looks at a new claim which has been submitted, its important that they have satisfactory information at their fingertips to conduct the coverage analysis.

If the insurer has all relevant documents and available information, then this will speed up the process significantly and reduce delays.

A chronology is a great way to collate that information and will also assist in speeding up the process.

A claims officer will not conduct a coverage analysis and will not be able to advise on indemnity if they don't have all relevant information, so its really important that the insured and their broker put everything together into an information package to give to the insurer. This should include:

1. A chronology of facts, to save the insurer time
2. Copies of relevant documents
3. An estimate of quantum of loss

Step 2: Review the Insuring Clause

The insuring clause is the key provision in an insurance policy that specifies the risks covered by the insurer. In other words, it details the risks for which the insurer is liable and defines the scope of the coverage.

Its often found at the start of a policy, but as policies have developed and composite or modular (packaged) products have become more popular, some policies have more than one insuring clause. Some products contain a preamble containing important information, but in order to assess coverage, you will first need to identify and understand the insuring clause.

For example, a Management Liability policy has a number of different insuring clauses each relating to specific insured events or defined covers. Here is an example of an insuring clause for the directors & officers liability section of a Management Liability Policy:

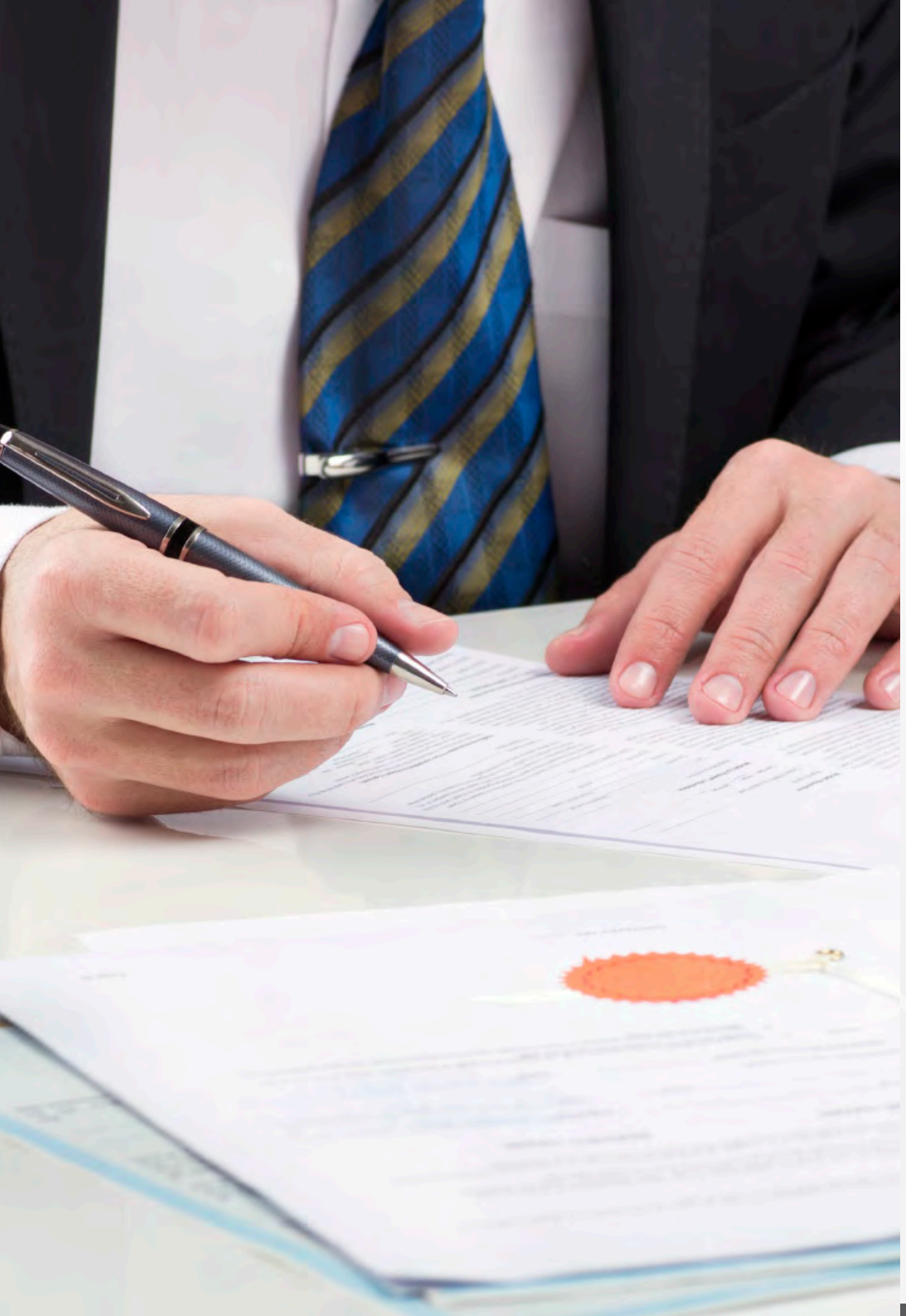
> **We will pay on behalf of any director or officer any loss incurred in that capacity in respect of any claim made against such director or officer and notified to us during the insurance period for a wrongful act for which that director or officer is not indemnified by the company.**

Step 3: Review any relevant Extensions of Cover

An extension of cover is a clause in a policy which provides for coverage of losses beyond the coverage provided in the insuring clause.

Insurers may use extensions of cover as a marketing tool, to highlight the various situations that a policy will respond to and provide valuable additional coverage outside of the insuring clause; or clarify if the Insuring Clause is silent (for example affirmative cover).

Extensions of cover should not be accessible unless the insuring clause has been triggered, although this is not always the case, as many extension clauses may be coverage clauses in their own right or provide value added benefits that don't require the insuring clause to be triggered. If the Insuring clause isn't triggered, it might not necessarily be a *fait accompli* in the coverage assessment process, as an Extension of cover might come to the rescue and save the day.



Step 4: Review any relevant Exclusion Clauses

Exclusion clauses are what an insurer won't cover. For example the policy says, "we'll cover everything we state we'll cover, unless its excluded". Hopefully you've looked through the exclusion clauses before you've purchased the policy to figure out whether the policy will respond or not, but all too often the buying decision is influenced by price, rather than breadth of cover and the insured hasn't focused on the exclusion clauses until they have a claim.

Exclusion clauses are often more important that the insuring clause, as the insuring clause is designed to be sufficiently broad enough to pick up most things within the spirit of the policy, unless the exclusions specifically carve that coverage out.

Common exclusion clauses can include:

- An insolvency exclusion which excludes claims relating to the insolvency or financial impairment of the policyholder.
- Prior and pending exclusions, which exclude claims or investigations commenced prior to the inception of the policy.
- Pollution exclusions, which exclude claims arising from pollution. Pollution is often a defined term and may mean different things in different policies.
- War and terrorism exclusions, which exclude claims arising from act of war or terrorism.

Step 5: Review any relevant Conditions

Conditions are generally the section of an insurance policy that identifies general requirements of an insured and the insurer on matters such as loss reporting and settlement, property valuation, other insurance, subrogation rights, and cancellation and non-renewal. Conditions are often found in a separate section of a policy and in packaged or modular products common terms and conditions may apply.
A thorough review of the conditions section of the policy is necessary in order to ascertain whether there are any provisions that relate to the coverage position of a claim.

Step 6: Review any relevant Defined Terms

The English language is a wonderful thing, but for the purposes of an insurance contract, the usual English language meanings of words are rarely precise enough, so insurers tend to give words specific meanings defined in the policy. It is important for an insurance contract to be clear and unambiguous, so it makes sense that an insurer will be specific in giving the words that they use an exact meaning.

It isn't enough to simply read the terms of a policy without bearing in mind the defined terms that those words might have.

The best example of that is the word "claim". What do you think about when you hear the word "claim". You may have answered: "well a claim is when you come to the insurer and make a claim on the policy". That's right, unless the policy defines what the insurer means by the word claim. For example, here is the definition of the word claim in a common Australian Management Liability wording:

Claim means:

(a) Any written demand for compensation, monetary damages or other relief, including non-monetary relief, made against the insured alleging a wrongful act or corporate wrongful act; or

(b) Any formal notice of criminal, civil or arbitration proceedings (including extradition proceedings or execution of a warrant for arrest) against the insured alleging a wrongful act or a corporate wrongful act; or

(c) Any formal regulatory or administrative proceedings or any other official investigation with regard to any allegation of a wrongful act committed by the insured persons or a corporate wrongful act committed by the company.

So insurers may give words that have a usual meaning in the English language different meanings for the purposes of the policy. In order to properly assess indemnity, you will need to refer to the definitions of all of the words appearing in any insuring clause, extension, endorsement, exclusion or condition.

Step 7: Review any relevant Endorsements and the Policy Schedule

A policy of insurance is a contract. The policy itself is usually a standard wording that can apply to any insured. The insurer may then use the Policy Schedule and any Endorsements to tailor the coverage to a particular policyholder. The Schedule sets out things like the name of the policyholder, the period of insurance, the limit of liability, the excess (sometimes called the retention or deductible) and any sub-limits of cover that have been applied to the risk.

An endorsement is an amendment or addition to the policy which may change the terms or scope of the wording. An insurance endorsement may be issued mid-term, at the time of purchase, or at renewal. The purpose of an endorsement is a policy change. Insurance companies create endorsements to offer options to insureds to add coverage or increase coverage limits, but insurers may also issue special endorsements to limit or restrict coverage.

So the policy wording will provide the base level, off the shelf version of cover and any special terms and conditions that have been applied will be done so via the endorsement. Because the endorsements are so unique to a given risk and have been applied by the underwriter with the policyholder's specific circumstances in mind, its crucial that the endorsements are properly reviewed before you can formulate your indemnity position.

It isn't enough to simply read the terms of a policy without bearing in mind the defined terms that those words might have.

Step 8: Review any relevant law

The most common law which assists in interpreting a contract of insurance in Australia is the *Insurance Contracts Act 1984* (Cth.) which provides some guidance in interpreting insurance contracts.

You shouldn't really need to refer to the Insurance Contracts Act, because the drafting of the policy should be sufficiently clear as to enable the reader to interpret the coverage being provided easily, however, all too often, grey areas come up because of some unforeseen facts, which the drafter may not have considered, or because of some ambiguity in the language used. When the policy is unclear, the Insurance Contracts Act provides the framework within which the policy is to be read. Here we discuss a number of the more commonly referred to parts of the Insurance Contracts Act that can have an impact on coverage.

The Insurance Contracts Act is quite a large document, so I won't go into chapter and verse in this paper explaining the entire thing, but its enough to know of its existence and it is a reference.

Section 21 of the Insurance Contracts Act provides that before you enter into a contract of general insurance with an insurer, you have a duty to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, upon what terms. You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of general insurance.

Your duty, however, does not require disclosure of a matter:

- That diminishes the risk to be undertaken by the insurer;
- That is of common knowledge;
- That your insurer knows, or in the ordinary course of its business, ought to know;
- As to which compliance with your duty of disclosure is waived by the insurer.

Section 28(3) of the Insurance Contracts Act provides that if an insured fails to comply with their duty of disclosure, the insurer may be entitled to reduce their liability under the contract or may cancel the contract. If an insured's non-disclosure is fraudulent, the insurer may also have the option of avoiding the contract from its beginning.

Section 37 of Insurance Contracts Act provides that an insurer may not rely on an unusual provision in a contract of insurance unless the insurer clearly notifies the insured in writing of the effect of the provision before the contract was entered into. In the event that an insurer applies an endorsement to a policy after its inception, then it may be argued that this provision has not been adhered to, meaning that the insurer can not rely on the clause.

Section 40(3) of the Insurance Contracts Act provides that where the insured gives notice in writing to the insurer during the Insurance Period of facts that might give rise to a claim against the insured, the insurer cannot refuse to pay a Claim which arises out of those facts, by reason only that the Claim is made after the Insurance Period has expired.

Under section 45 of the Insurance Contracts Act another insurance clause is void, unless the other insurance is specifically noted. What is an "other insurance clause" though? It's a clause that says something along the lines of "if there is another policy that might also cover the same risk, the cover under the policy will only apply once the other insurance policy limit has been exhausted". This can become an issue when an insured purchases two policies that may afford similar cover, but each policy contains has an Other Insurance clause. What happens if each insurer refuses to pay until the other has paid? The Insurance Contracts Act says that these clauses are void and an insurer can't rely on them, so the situation then becomes one of dual insurance. For an Other Insurance clause to be valid, the clause must specifically state the other insurance policy that it is referring to, rather than just being a blanket prohibition on other insurance.

Section 54 is one of the most controversial and litigated clauses in the Insurance Contracts Act. It has the effect that an insurer may not deny indemnity based on a technical breach of the policy or other act or omission after the policy was entered into unless the breach, act or omission could reasonably be said to have caused or contributed to the loss the subject of the claim.

Another important area of law to consider is the doctrine of *contra proferentum*, also known as "interpretation against the draftsman", it is a doctrine of contractual interpretation providing that, where a promise, agreement or term is ambiguous, the preferred meaning should be the one that works against the interests of the party who provided the wording.

The reasoning behind this rule is to encourage the drafter of a contract to be as clear and explicit as possible and to take into account as many foreseeable situations as it can. If you have been through the 10 steps outlined in this guide and still can't get an answer that is clear, then its likely that the policy wording is ambiguous. In this scenario, if there is a dispute, a court would find against the drafter of the policy based on the doctrine of *contra proferentum*. In most cases, the insurer is the drafter of the policy, but in some situations, an insured may have their own wording that they prefer or a broker may provide a wording.

One should also be mindful of any laws that prohibit an indemnity from being granted. These are certain laws where the state has made the decision to enact legislation which prohibits an insured from purchasing an insurance policy to indemnify them against certain acts. There is a common law premise that intentional criminal conduct is uninsurable, although defence costs for alleged criminal conduct may be advanced.

This list is not an exhaustive list of all of the law that you need to consider but touches upon the main areas of law that apply to Australian contracts of insurance. If you require further advice as to whether there are any laws that apply to facts or circumstances of a claim, you should contact a lawyer and obtain advice.

Step 9: Apply the facts to the relevant Policy terms and conditions and/or any relevant law

Now you have ascertained the relevant facts, reviewed the relevant sections of the policy and any relevant law, you have all of the information available to apply the policy terms and conditions to the facts. This is the part of the process where everything should start to come together, provided steps 1 to 9 have been completed thoroughly.

If you are aware of the relevant facts, know how the policy operates and how the facts and policy fit within the law, then the indemnity position should start to become clear and you should be able to begin to formulate a coverage position.

However, when an indemnity position isn't 100% clear, this is where the process can start to unravel. It might be the case that an insurer will need to go back and request further information, or even obtain an opinion from an expert to help ascertain the facts and apply them to the policy terms and conditions and any relevant law. Obtaining expert opinion can slow the process down significantly, causing further frustration from insureds.

Insurers are in the business of paying claims and have in place systems to quickly and efficiently settle claims. It isn't in the insurer's interest to have a claim sitting around unresolved for months and months. If a claim is covered, then the claim should be paid promptly, as failing to pay can cause issues for the insurer under the General Insurance Code of Practice and may lead to the insured making a complaint.

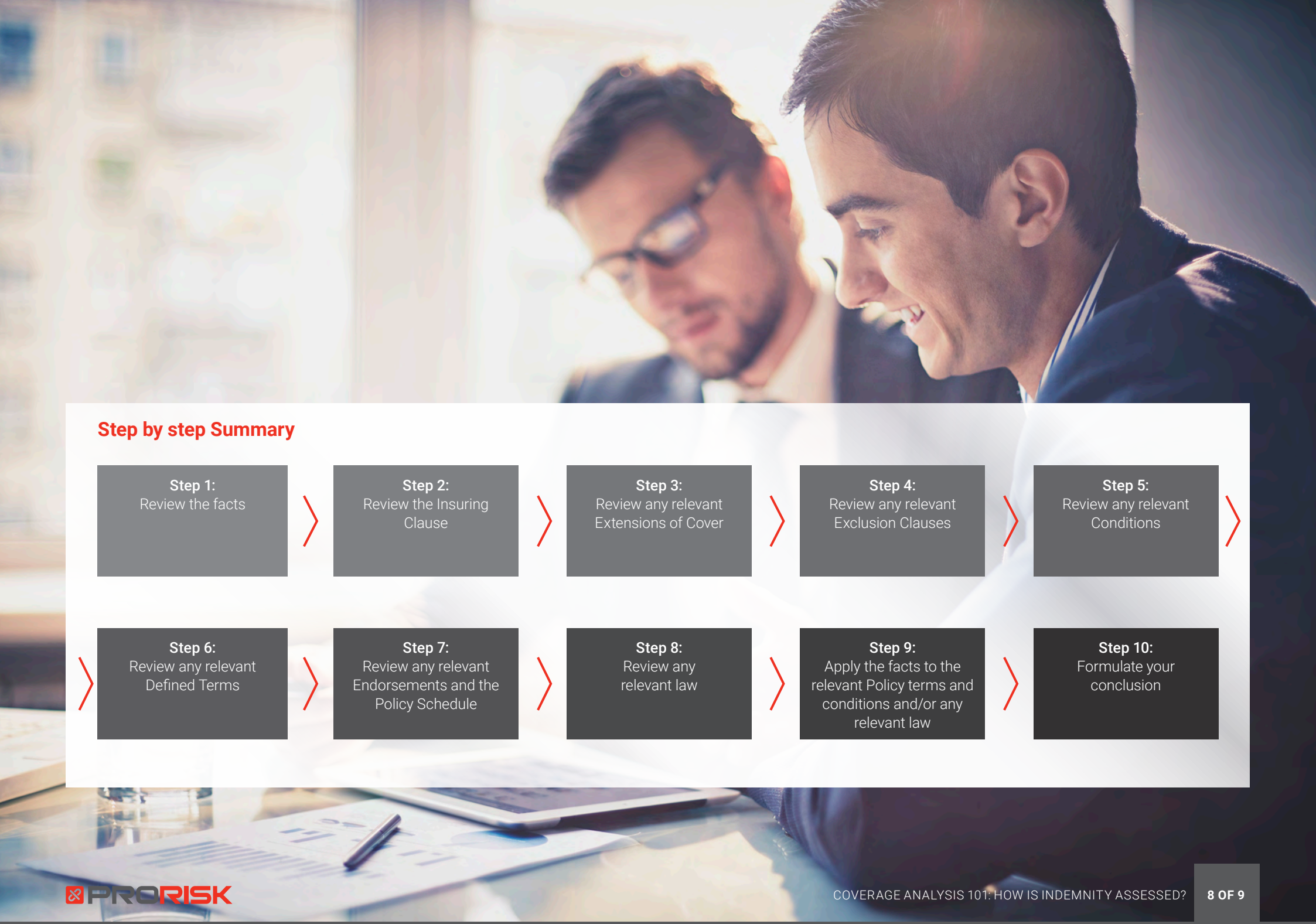
Step 10: Formulate your conclusion

The final step in the process is to formulate your conclusion. If you have been through steps 1 to 9 and there is nothing that you have explicitly come across that would exclude the claim and the insuring clause responds, then your claim should be covered.

In my experience there are times when a claim is submitted to a claims department and an insured or broker wants to know immediately whether or not the claim will be covered. They want an instant “yes” or “no” answer. Generally speaking, making a coverage decision may be straightforward. Where the claims are relatively low value and high volume, the insurer will want to resolve the claim swiftly rather than drag out and incur further costs. The more complex the facts, or the more complex the policy type, the more likely it is that delays in assessing the indemnity position will be experienced. For example, where there are multiple parties, complex projects, investigation costs to determine causation or where multiple parties have been joined to proceedings, all of which may have contributed to a loss.

Insurance companies require their claims staff to conduct a coverage analysis, whether its completed in house or outsourced to a third party, before their claims staff are allowed to advise the insured and their broker of an indemnity position. Its often this disconnect between the insured wanting an instant response and the insurer requiring claims staff to complete satisfactory due diligence, which can cause friction and be the cause of complaints against insurers.

A thorough understanding of the process which a claims officer must complete will hopefully remove some of that friction and ensure a timely review of an indemnity position, speeding up the process and making life easier for all.



Step by step Summary

Step 1:
Review the facts

Step 2:
Review the Insuring Clause

Step 3:
Review any relevant Extensions of Cover

Step 4:
Review any relevant Exclusion Clauses

Step 5:
Review any relevant Conditions

Step 6:
Review any relevant Defined Terms

Step 7:
Review any relevant Endorsements and the Policy Schedule

Step 8:
Review any relevant law

Step 9:
Apply the facts to the relevant Policy terms and conditions and/or any relevant law

Step 10:
Formulate your conclusion

Top 5 tips for making sure your claim is handled expeditiously

1. **Do what you can to mitigate the loss**

   Insureds have a common law duty to mitigate their loss. If you are able to stop the loss from getting any worse by taking decisive action, then you should do it! (Although keep in mind Tip number 5 below)

2. **Contact your insurance broker as soon as possible**

   Your insurance broker is your adviser and will be able to help you navigate the claims process.

3. **Provide all the information that you have available at the outset.**

   Your insurer needs to get certain information from you to be able to make a coverage decision and getting you to fill in a form is one of the most efficient methods of getting the right information from you.

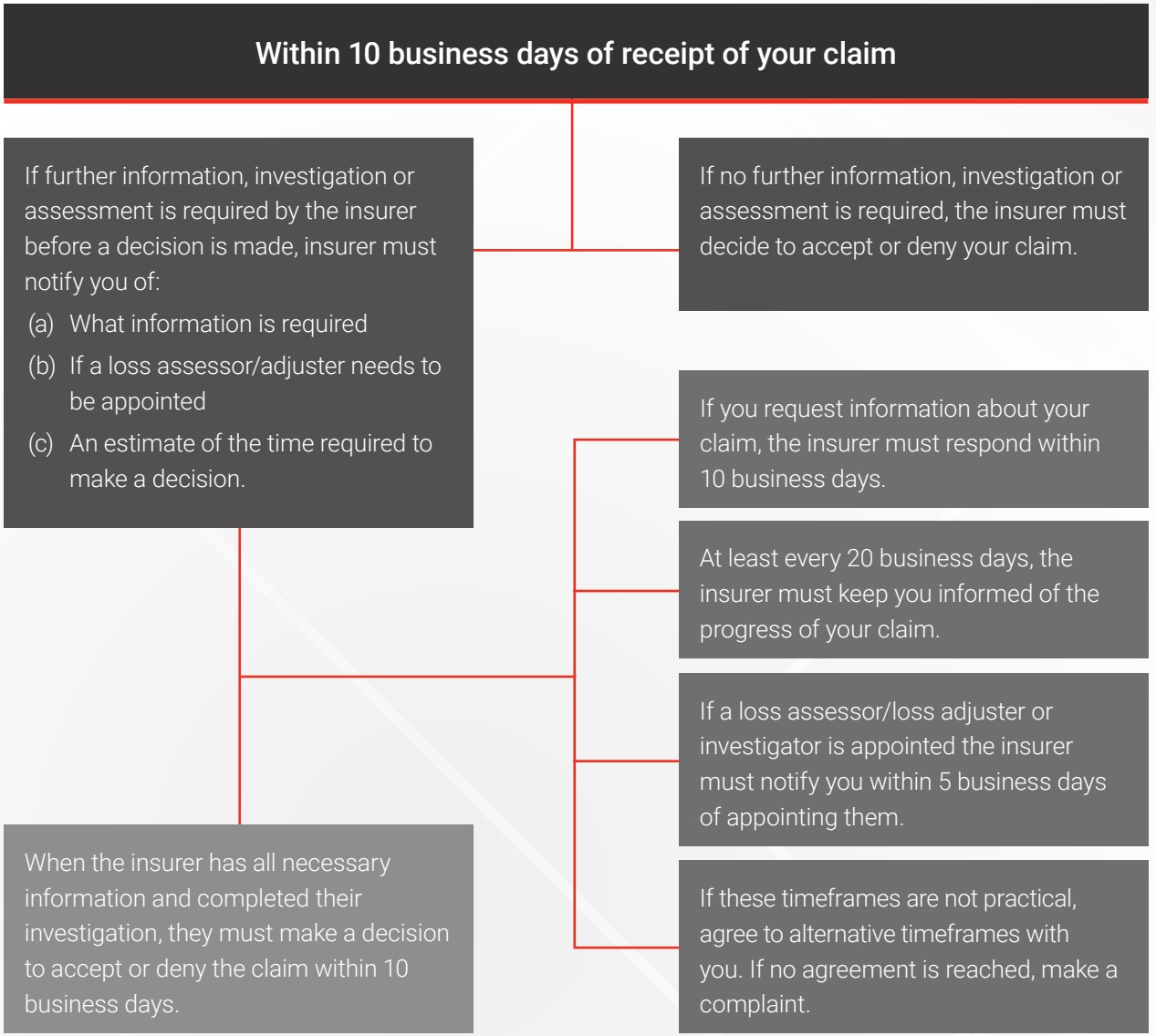
4. **Co-operate with the insurer**

   Taking an adversarial stance is the wrong attitude. Your insurer is there to help you through the claims process.

5. **Talk to your insurer before spending any money**

   Often, your insurer has helped many others through similar situations to what you're going through and will have agreed rates with experienced service providers.

The following flow chart outlines the timeframes that apply to insurers under the *General Insurance Code of Practice* once they receive written notification of a claim:



In addition to the above, where a claim is made under one of the following classes of insurance policies:

- Motor vehicles
- Home building
- Home contents
- Sickness and accident
- Consumer credit; or
- Travel

The following deadlines apply to making a decision on a claim

If further information, investigation or assessment is required:

If no exceptional circumstances apply, the insurer must:

(a) make a decision to accept or deny your claim within 4 months of receipt of your claim

(b) if no decision is made, inform you of your right to complain to IDR or EDR (e.g. AFCA).

If exceptional circumstances apply, the insurer must make a decision to accept or deny your claim within 12 months of receipt of your claim.

Source:
https://insurancelaw.org.au/factsheets/my-insurance-claim-is-taking-forever-factsheet/

About the author

Jaydon Burke-Douglas is a qualified solicitor and insurance professional with over 15 years experience in the insurance industry. He has a wealth of knowledge from his experience in claims management, product design, underwriting and legal roles at some of Australia's largest insurers. He has a passion for helping policyholders and brokers navigate the complex world of insurance by simplifying processes, demystifying the bureaucracy of the decision making processes and making insurance products easier to understand.